PRINTED: 04/29/2010 FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS82AGC 04/05/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 720 S NINTH STREET **BEST CARE FACILITY 1** LAS VEGAS, NV 89101 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 000 **Initial Comments** Y 000 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a required grading re-survey conducted in your facility on 3/31/10 and 4/5/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 18 Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness. The census at the time of the survey was 14. The facility received a re-survey grade of A.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE